

INSTRUCTIONS FOR REQUESTS FOR FINANCIAL HARDSHIP MEDICAL AND DENTAL EXPENSES WORKSHEET

PART I

Date

Enter date you are completing the form.

Parent/Guardian

When two parents are in the home, please list both names.

Child Name and Birth Date

Enter the name and birth date of the child who is receiving early intervention services. If there is more than one child receiving services, use a separate form for each child.

Family Resources Coordinator

Enter the name of the Family Resources Coordinator.

Local Lead Agency or Service Provider

Enter the name of the local lead agency, service provider agency or individual service provider.

PART II

List the names and birthdates including yourself, spouse, children, and other family members living in the home dependent on you for their support.

PART III

Please include all medical and dental expenses incurred and private health care deductibles, co-pays, and co-insurance paid for the last 12 months for each family member listed in Part II. Attach additional sheets if necessary.

Column 1

Family Member Name

Enter the names of the family members listed in Part II.

Column 2

Medical/Dental Total Expenses

Enter the total medical/dental expenses for each family member listed above for the last 12 months.

Column 3**One-Time Expense or Carryover from Previous Year**

Enter the amount of any one-time expense. Also, include any carryover expenses from the previous year, if applicable.

Column 4**Total Amount the Family Must Pay**

Enter the total amount the family must pay. This includes deductibles for the child who is receiving early intervention service, co-pays, and/or co-insurance for the last 12 months.

Column 5**Total Amount Paid by the Family**

Enter the total amount already paid by the family.

Column 6**Total Amount Owed**

Subtract column 4 from column 5 and enter the total amount left owing by the family. Column 6, Line 7 is the total medical/dental expenses owed.

Monthly Medical Dental Expenses

Column 6, Line 8 Monthly Medical/Dental Expenses equals line 7 \div 12 months.

Please sign and date the document and return the form to your Family Resources Coordinator (FRC).

Financial Hardship

Medical/Dental Expenses (**Total on line 7 divided by 12.**) divided by the Current Monthly Income (**See Current Monthly Income and Allowable Expenses Worksheet to calculate current monthly income**) equals percentage of current monthly income. The percentage must exceed 5% of the family's calculated current monthly income to approve a financial hardship.

FRC or Other Authorized Person and Date

The signature of the FRC or authorized Person and the date.